FX-0003-0503

STATE OF NEW JERSEY
DEPARTMENT OF THE TREASURY
DIVISION OF PENSIONS AND BENEFITS

PO Box 295
Trenton, NJ 08625-0295

ADDITIONAL CONTRIBUTIONS TAX-SHELTERED (ACTS) PROGRAM
SALARY REDUCTION AGREEMENT

Name _____ _____ _____
LAST FIRST MIDDLE INITIAL

Social Security No. _____

Retirement System (IF APPLICABLE) ☐ PERS ☐ TPAF ☐ PFRS

Membership No. (IF APPLICABLE) _____

Address _____
STREET OR R.D.# APARTMENT NO.

_____
CITY STATE ZIP

Daytime Telephone Number (_____) _____

The above named employee and the State of New Jersey agree that the employee's eligible earned base biweekly salary will be reduced by voluntary contributions beyond those required by mandatory membership in any state-administered retirement system. The amount of reduction shall be _____% and will take effect on the date certified below. This reduction shall not exceed the employee's statutory exclusion allowance under Section 403(b) or the limitations of Section 415 and the regulations thereunder of the Internal Revenue Code. The voluntary contributions will be allocated and forwarded as directed on the employee's most recent Carrier Election and Allocation form.

This agreement shall be legally binding as to each of the parties hereto while employment continues; provided that either party may terminate this agreement as of the end of any month, so that it will not apply to salary subsequently earned, by giving at least 30 days written notice of the date of termination; and provided further, that no more than one agreement for such salary reduction may be made within any calendar quarter.

Check one: ☐ **Initial Agreement** ☐ **Change Percentage** - (LIMITED TO ONE PER CALENDAR QUARTER) ☐ **Suspend Contributions**

Employee Signature: _____ Date: _____

EMPLOYER SECTION

Name of Employing Agency _____ Payroll No. _____

Address of Employing Agency _____

Certifying Officer Signature _____ Title _____

Telephone Number _____ Date _____

Mail completed form to: **Division of Pensions & Benefits, ACTS Program, PO Box 295, Trenton, NJ 08625-0295**

FOR DIVISION USE ONLY

SALARY REDUCTION AGREEMENT - CONFIRMATION OF RECEIPT BY DIVISION OF PENSIONS AND BENEFITS

Effective Date _____ Authorized Signature _____ Date _____

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SALARY REDUCTION AGREEMENT

GENERAL INFORMATION

Employees of county colleges, state universities and colleges, the Commission on Higher Education, the Department of Education, and the Office of Student Assistance can participate in the Additional Contributions Tax-Sheltered (ACTS) Program. ABP members have the option to select the same individual carriers through the regular Alternate Benefit Program.

The Salary Reduction Agreement establishes a contract between you and the State of New Jersey. A Salary Reduction Agreement must be filed to establish participation and each time you change your percentage of reduction. However, only one ACTS Salary Reduction Agreement initiating a change may be filed per calendar quarter. For this purpose, the suspension of contributions does not constitute a change. If you are a new participant, this form must be accompanied by the Carrier Election and Allocation form. A Carrier Election and Allocation form must be filed to identify the investment carrier(s) with which you want your contributions invested.

INSTRUCTIONS FOR APPLICANTS

Please read all information carefully when completing this form. Where applicable, indicate your name, mailing address, social security number, and telephone number where you may be reached during daytime working hours. If you are a member of a state-administered retirement system, check the name of the system and provide your membership number.

To authorize the reduction, indicate the percentage (in whole numbers only) of your base salary you elect to invest with any eligible carrier(s). The reduction amount shall not exceed your statutory exclusion allowance under Section 403(b) or the limitations of Section 415 and the regulations of the Internal Revenue Code. Indicate in the relevant box if this is an initial agreement, change, or suspension of contributions.

Sign and date the form and have your certifying officer complete the employer information. A copy will be returned to you after confirmation of receipt indicating the date your reduction will take effect.

Refer to the Carrier Comparison Guide for information on individual carriers. Before submitting forms to the ACTS Program, it is your responsibility to complete the necessary forms to establish a valid account with the carrier(s) you select for your investments. If you fail to establish an account with the carrier(s), you may lose earnings from your contributions. Additionally, the carrier(s) will return your contributions to the Division of Pensions and Benefits and your participation will be delayed.

INSTRUCTIONS FOR EMPLOYERS

Please enter the name, address, and payroll number of your agency. The designated certifying officer must sign the form indicating his/her title, telephone number, and the date. Upon completion, return this form to:

DIVISION OF PENSIONS AND BENEFITS
ACTS PROGRAM
PO BOX 295
TRENTON, NJ 08625-0295